Commentary

Latino Child Health: Need for Inclusion in the US National Discourse

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A B S T R A C T

The "rediscovery" of poverty, as echoed in concepts of social inequality, has contributed to the goal of eliminating racial/ethnic and social class disparities in the United States. This commentary focuses on what we know about the pressing health care needs and issues relevant to Latino children and families and how extant knowledge can be linked to priority policy recommendations to ensure the inclusion of Latino health issues in the national discourse.

A systematic review of the literature on Latino children and of expert opinion revealed 4 evidence-based themes focused on poverty: economic factors, family and community resources, health system factors, and pitfalls in Latino subgroup data collection. Consensus was found on 4 priority policy recommendations: (1) reduce poverty and increase access to health care coverage, (2) increase funding in targeted primary and preventive health care services, (3) provide funds needed to fully implement relevant health legislation, and (4) improve measurement and quality of data collection. If these recommendations are not instituted, the goals of Healthy People 2010 will not be achieved for the Latino population. (*Am J Public Health.* 2000;90:1827–1833)

Past US federal initiatives designed to reduce racial and ethnic disparities have given limited attention to health inequities in the Latino population.[1–3] An important question is the following: Given the historic presence of Latinos in the United States and the continuing increases in this population owing to population growth and immigration, why have Latinos failed to achieve inclusion in the national health policy agenda? There are several possible answers to this question.

First, Hispanics were not identified in the US census, on birth and death certificates, or in other national data systems until the past 2 decades.[4–6] Second, presentation of health data indicating relatively good health outcomes in spite of low socioeconomic status for Hispanics in the aggregate obscured important differences by subgroup, generation, birthplace, and time in the United States. The application of the term *epidemiological paradox* to findings of good health outcomes explained the Mexican-origin outcomes[7–12] but masked the heterogeneity of the Latino population. It also drew attention away from Latinos' limited access to care and disproportionate burden of chronic diseases such as adult diabetes and childhood asthma.

Third, Latino scholars and federal and local officials have been relatively absent at the national, state, and local levels. National Latino organizations focused on Latino health did not emerge until the late 1990s, and this resulted in a lack of advocacy at the national level. Finally, a limited empirical base was available to support claims for the disproportionate burdens of death and disability that constituted principal criteria for inclusion in the national health discourse.

Social and Economic Equality?

Healthy People 2010,[2] the national disease prevention and health promotion goals for the year 2010, has the overarching aim of eliminating disparities. For the first time, objectives have been set and baseline and monitoring data are presented for Latino subgroups.[13,14] The goal of eliminating racial/ethnic disparities requires a considerable scholarly investment if the reasons underlying disparities are to be understood; there has not been adequate research on inclusion and measurement of medical and nonmedical factors associated with Latino child and family health outcomes. Herein resides the concern that goals may not be achieved unless changes are implemented within a broader framework of social and economic equity and community resource development to improve Latino health.[15–19]

This commentary focuses on what we know about the pressing health care needs and issues relevant to Latino child and family health and how extant knowledge can be linked to priority policy recommendations to ensure the inclusion of Latino health in the national discourse. Although we focus on children, we do so in the context of their families.

Why Latino Children? Why Now?

Growth rates among the Latino population not only exceed those of other minority groups but also exceed the growth rate of the US population as a whole.[20,21] If projected growth trends continue, the Latino population will be the largest minority group in the United States, reaching a projected 96.5 million people (24.5% of the total US population) within the next 5 years.[22,23] Relative to Whites and African Americans, Latinos are a young popula-

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TABLE 1—Socioeconomic and Health Indicators for US Latino Children

	Latino, %	Black, %	Non-Hispanic White, %
Socioeconomic data			
Children in US population	15	15	65
Children in poverty	36	37	11
Families with children younger than 18 years living at home	64	36	76
Children in single-parent homes	31	55	21
Health indicators			
Access/use of services			
Children without usual source of care	17.2	12.6	6
Children without health insurance	27.7	17.6	12.2
Children with Medicaid coverage	32	37	14
Children with private health insurance	43	47	79
Families "unable to afford health care"	69.1	60.4	58.5
Children "in excellent health"	42.9	48.1	55.3
Children aged 1–4 years with no physician visit	11.7	11.1	8.4
Children aged 5–9 years with no physician visit	24.4	18.3	17.9
Youth aged 10–14 years with no physician visit	34.2	28.9	24.8
Adolescents aged 15–19 years with no physician visit	37	26.7	25.7
Risk behaviors			
12th graders reporting heavy drinking	14	8	27
12th graders reporting illicit drug use	24	20	27
10th graders reporting smoking cigarettes daily	9.4	5.8	20.3
Female youth reporting use of condom at most recent intercourse	40	58.9	49.2
Male youth using condom inconsistently or not at all	71	53	54
Teen births	17.4	22.8	11.3
High school girls attempting suicide	14.9	9	10.3
Preventive health behaviors			
Children not fully immunized	24	23	20
Children with active asthma	11[a]	6	3
Children aged 2–4 years with dental caries in primary teeth	32	22	13
Children aged 5–17 years with dental caries in permanent teeth	49	39	45
Boys aged 6–11 years who are overweight	18.8	14.7	13.2
Girls aged 6–11 years who are overweight	15.8	17.9	11.9

[a]Puerto Ricans.

tion. Approximately 35% of Latinos (vs 24% of Whites and 30% of African Americans) are younger than 18 years.[22]

The number of Latino children has already surpassed that of any other minority group, growing from 9% of the child population in 1980 to 15% in 1999. In 1998, the number of Latino children was estimated to be 10.5 million.[23] Although only 13% of Latino children were foreign born in 1996, 31% report having difficulty speaking English. By the year 2020, an estimated 1 in 5 children living in the United States will be Latino.[20]

Latino children account for a large and growing segment of the nation's student population (13.5%). States with high Latino elementary and secondary school enrollments include New Mexico (46.6%), California (38.7%), Texas (36.7%), Arizona (30%), Colorado (18.4%), New York (17.4%), Florida (15.3%), New Jersey (13.5%), Illinois (12.2%), and Massachusetts (9.3%).[22] The aforementioned demographic changes provide a compelling rationale for federal and state policymakers to include the health care needs of Latino children in their health policy agendas to achieve the Healthy People 2010 objective of eliminating ethnic disparities.

Table 1 displays selected socioeconomic and health indicators for Latino children in comparison with African American and non-Hispanic White children. Latino children are disproportionately represented among the poor in the United States. In 1998, 34.4% of Latino children lived in poverty, although there were significant differences among subgroups. Puerto Rican children (43.5%) are most likely to live in poverty, followed by Mexican American (35.4%), Central and South American (26.6%), and Cuban (16.4%) children.[22]

Latino children are more likely to be uninsured than African American or non-Hispanic White children.[19,24–29] Mexican Americans are the Latino group most likely to be uninsured.[30] High rates of noncoverage are associated with the following 2 factors: parents working in economic sectors that lack employment-linked health benefits[19,24,28,31,32] and multiple and persistent barriers experienced by Latinos in accessing health care.[27,29,33–39] More than one third (36%) of Medicaid-eligible Latino children are not enrolled, and only about 32% of eligible Latino children receive Medicaid benefits.[35,37,40,41] Among Latino children, lack of health insurance is strongly associated with greater use of emergency rooms as a source of primary care,[33,36,42] less likelihood of having a usual source of care,[29,34,37,43] and less contact with a physician in the previous year.[44,45] The older the Latino child, the more likely he or she is to have no physician contact relative to his or her African American and non-Hispanic White peers.

Available evidence shows that in comparison with African American and non-Hispanic White children, Latino children generally (1) are less likely to be immunized,[43,46–51] (2) have higher rates of tuberculosis,[52,53] (3) have higher rates of obesity and sedentary activity,[54–59] (4) have more dental caries,[43,57] (5) are more likely to experience intentional and unintentional injuries,[60–62] and (6) are more likely to reside in hazardous environments.[21,43,63–65] Latino adolescents are more likely to use drugs, alcohol, and tobacco[21,43,66]; less likely to use contraceptives[67,68]; more likely to be injured[21,43,66]; and more likely to attempt suicide than African American and non-Hispanic White adolescents.[69–71]

Evidence-Based Themes: What Do We Know About Latino Child and Family Health?

Four major themes emerged from the body of evidence reviewed[72–74]: (1) the role of socioeconomic status and its strong associa-

tion with health insurance coverage and adverse health outcomes[15,19,24,25,27–29,31,35,40,65,75,76]; (2) the importance of family and community resources in improving Latino child health[76–97]; (3) health system factors as key predictors of use of services, compliance behaviors, and health outcomes[33,34,36,47,52,98–104]; and (4) the recognition that Latinos are not a homogeneous group.[105–113]

Economic Factors

Economic factors as predictors of health access and outcomes were notably more likely to be included in post-1991 investigations of Latino health.[18,34,35,40,41,48,75,76] In comparison with African Americans and non-Hispanic Whites, Latinos are more likely to report that they are unable to afford health insurance, more likely to work in employment sectors that do not have employment-linked health benefits, and less likely to access public benefits such as Medicaid.[19,24,27,31,35,40] Although language is a barrier to access, ethnic disparities have been shown to persist even after limited English-language proficiency has been taken into account.[21,42,101,114]

Several recent reviews of the literature on access among Latinos substantiate the links between socioeconomic status and health.[3,15,24–26,28,29,46,76,115] Low socioeconomic status is a significant determinant of health status and outcomes for Latino children and accounts for a substantial proportion of ethnic-specific group disparities in morbidity and mortality patterns.[24–26,28,32,76,116,117]

Family and Community Resources

Familial behaviors and community resources have been identified as key factors in promoting children's physical and mental well-being.[76–97] Parental factors, particularly education and literacy levels, play a direct role in Latino children's health access and outcomes.[39,47,52,61,96,98] Families, often not aware of services or fearful of providers, place Latino children at risk for less use of preventive screening services, more lost school days, and potential health problems in adulthood.[4,29,91,100] Providers' involvement with parents may significantly increase the use of preventive and primary care services.[36,38,92]

Resources available in a community are linked with availability of health care services and are powerful determinants of use of preventive and primary care services and of health outcomes.[15,34,35,41,47,77,78,118] Health care services, often overburdened or entirely lacking in low-income Latino communities, are not able to adequately respond to the needs of Latino children.[15,76] Therefore, working in partnership with the community and its families to develop ethnic-specific clinical screening services, parent education, and outreach programs can help improve Latino children's health.[77,78,80,81,83,85,88,89,91,92,94,96,98] School health clinics, community prevention efforts, disease-centered outreach programs, and pediatric clinics are some of the innovative interventions that have proven effective.[36,41,77–80,82,84,86,87,95,97]

Health System Factors

Institutional systems and barriers are consistently identified as powerful predictors of parental health behaviors, use of services, and child health outcomes.[33,34,36,47,52,98–104] Institutional factors include provider attitudes, availability of translators, waiting times, location, and other nonfinancial barriers.[27,36] Access to the health care system does not ensure that appropriate services will be provided or that a child's health will improve. Inequities in use of preventive and primary care services have been documented with respect to vision screening, prescription medications and equipment for the management of asthma, and access to and use of mental health services.[31,33,38,98,99,116,117] Changes in health system factors can best be achieved by implementing and monitoring the US Department of Health and Human Services cultural competency guidelines as well as civil rights guidance for limited English proficiency (Executive Order 13166, issued on August 11, 2000), and by increasing the numbers of bilingual and bicultural providers.[13,14,118]

Pitfalls in Latino Subgroup Data Collection

Authors have consistently observed that health outcomes can be explained by subgroup differences.[105–113] Although significant progress has been made in the identification and collection of data on Latino health, several methodologic limitations hinder researchers' ability to fully capture disease and disability trends among Latino subgroups.[6,13,14,119] These limitations include the following: aggregation of all Hispanics into one group for analysis, without precise measurement of socioeconomic status; limited reporting of age and sex breakdowns, especially in studies of Latino children; and exclusion of Spanish-speaking populations, predominantly immigrants, because most national survey instruments are published in English.[4,5,13,14,118–121] Current federal and state data systems are also limited in terms of Latino child health indicators.[64]

A systematic review of approximately 200 studies on Latino children revealed several methodologic limitations: more than 60% of the studies did not report a method of ethnic identification; most reported data for Hispanics as an overall group; and almost half did not report an indicator for socioeconomic status. Also, because more than 50% of the studies involved secondary data, there was often an absence of relevant medical and nonmedical factors to explain the findings.

Most research has focused on Mexican-origin children, with an emphasis on nutrition, obesity, and physical fitness. Such studies often cite data derived from the Hispanic Health and Nutrition Examination Survey[39,50,113,122–126] or the third National Health and Nutrition Examination Survey, which included only Mexican Americans.[55,56,127,128] A recent review of Latino child health revealed that major research gaps include lack of subgroup data on parental and child health behaviors, chronic childhood illnesses, intentional and unintentional injuries, environmental health, migrant and US–Mexico border resident health, and mental health.[101]

Measurement of a broader array of factors, such as community context, parental and child health behaviors, and other lifestyle factors, is important for understanding the links between poverty and adverse health outcomes.[16,17,39,76–80,96,101,117] Broadening the scientific paradigm for understanding Latino child health involves examining the links among family, community, and cultural protective factors and institutional factors.[49,56,77,80,84,101,117] Although data limitations and research gaps have impeded the strategic process of including the needs of Latino children in the national health discourse, sufficient evidence now exists to inform priority policy recommendations.[29,102,129–131]

Policy Recommendations

A panel of 7 experts on Latino child health convened for a 2-day meeting in July 1999 to review what is known about Latino family and child health and to link the evidence to priority policy recommendations. The experts forged a consensus on 4 priority policy areas for promoting long-term, favorable Latino child health outcomes (see Table 2). These policy issues were as follows.

1. Decreasing rates of poverty among Latino families and children call for legislation and policies that promote economic equity by guaranteeing a minimum living wage, providing employment-linked health benefits,[19,28] and increasing access to adult education and literacy programs.

2. The most pressing policy area for Latino families and children is lack of access to health care.[15,24,25,27,29,32–37,39] Expanding access to health care services for Latino children and their families requires raising eligibility cutoffs to 250% of the poverty level for Medicaid, the State Child Health Insurance Program, and prenatal care programs for poor and working-class Latino families, especially those without employee-linked health benefits. Although many Latino families are eligible for such services, enrollment is low.[28,41,132,133] For example, Texas has extremely low Medicaid

TABLE 2—Evidence-Linked Findings and Priority Policy Recommendations: July 1999

Finding	Recommendations
Socioeconomic status is significantly linked to lack of health insurance	Decrease rates of poverty Guarantee minimum living wage Provide employment-linked health benefits Provide access to adult education and literacy programs Increase access to health care Raise eligibility to 250% of poverty level for federal and state programs Increase funding for outreach to promote awareness of programs & enrollment Monitor compliance with public charge guidance
Families & community resources are key factors for improving child health	Increase funding for primary and preventive care services targeting younger children Address high-priority areas of health Increase funding for school and mental health services
Health system factors are important predictors of health behaviors, use of services, and health outcomes	Provide sufficient allocations of funds to fully implement: Disadvantaged Minority Health Improvement Act Health Professions Partnership Act Cultural competency guidelines Civil rights guidance for limited English proficiency
Latinos are not a homogeneous group	Improve measurement and quality of data collection Strengthen quality of data in state vital statistics registries Implement standard administration of surveys in Spanish Report national and state data by at least 3 homogeneous subgroups

eligibility cutoffs, and a large number of Latino children remain uninsured.[133] To increase enrollment, additional funding is needed for informational outreach on eligibility via Spanish-language media and at sites such as public health clinics, schools, and churches. In addition, compliance with US public charge regulations is recommended to ensure that eligible legally-resident families enrolling in the State Child Health Insurance Program, Medicaid, or other noncash benefit programs will not jeopardize their immigrant status.[76,83,91,94–96,134]

3. Directly associated with documented health system inequities is the recommendation to increase federal and state funding for research and targeted preventive and primary care interventions that address identified health priority concerns of Latino children and families.[31,33,38,98,99,116,117] Family-focused primary and preventive health care services located in the community (with schools as important "windows of clinical opportunity") can effectively decrease health risks for children and families.[80–87,91–97] Ethnic-specific preventive and primary care services must be accompanied by sufficient authorization of funds to fully implement the 1990 Disadvantaged Minority Health Improvement Act, the Health Professions Partnership Act of 1998, and civil rights guidance for limited English proficiency.[3,6,13,14,118,121] Focused investments for the education, training, and hiring of bilingual and bicultural providers, particularly for the historically underrepresented Latinos, and enforcement of compliance with the Department of Health and Human Services cultural competency guidelines can significantly contribute to the aim of eliminating ethnic disparities.[118]

4. Although significant progress has been made in data collection, problems persist in the measurement and quality of data collected. To ensure the development of more comprehensive baseline indicators and the monitoring and surveillance of health indicators for Latinos, public health data systems must be improved through collection of minimal core information on racial/ethnic subgroups, place of birth, education, and English-language proficiency levels; administration of surveys in Spanish to ensure representation and inclusion of Latinos who have difficulty with English; and reporting of national and state data for at least 3 major Latino subgroups.[4,5,6,12–14,26,40,64,119,135,136] These data can yield community-specific baseline indicators. In 1998, the National Center for Health Statistics began the administration of Spanish-language instruments for the National Health Interview Survey; bilingual instruments should routinely be used in public health data collection procedures.[4] Progress in collecting baseline data is particularly important, as seen in the fact that 21% of the goals of Healthy People 2000 were not assessable.[115]

Conclusions

These policy recommendations derived from a literature review and from expert opinions show that health equity cannot be achieved without simultaneously improving economic equity to offset the effects of poverty on health outcomes for Latino children.[16,18] Current state programs such as the Children's Health Insurance Program and Medicaid access to prenatal care programs[132,137] can most effectively address access to care for low-income and working poor Latino families and children. The literature also reveals that access to clinical preventive screening and primary care services is necessary to reduce inequities in Latino child health.

These policy recommendations are neither new nor innovative, but they confirm those made in the past[1,120,121,138,139] and are consistent with recent federal initiatives.[13,14,118] In answering the question of why Latinos have failed to achieve inclusion in the health policy agenda, we suggest that past lack of political representation, combined with methodologic limitations, has significantly contributed to the exclusion of Latino health from the national discourse.

Recent reports such as *Hispanic Agenda for Action*[121] and *Healthy People 2000 Progress Review*,[115] along with the 1999 health workshop of the Hispanic Congressional Caucus Institute, reinforce policy priorities similar to those described here. Our data provide additional evidence of a compelling scientific consensus on the public health needs and priority policy recommendations necessary to ensure social and economic equity and reduce health disparities for low-income Latino children and their families. □

Contributors

R. E. Zambrana planned, designed, and conceptualized the study and wrote the paper. L. A. Logie contributed to the conceptualization and writing of the paper.

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